MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

Eighty-First Session
March 10, 2021

The Committee on Commerce and Labor was called to order by Chair Sandra Jauregui at 1:32 p.m. on Wednesday, March 10, 2021, Online. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/81st2021.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Sandra Jauregui, Chair
Assemblywoman Maggie Carlton, Vice Chair
Assemblywoman Venicia Considine
Assemblywoman Jill Dickman
Assemblywoman Bea Duran
Assemblyman Edgar Flores
Assemblyman Jason Frierson
Assemblywoman Melissa Hardy
Assemblywoman Heidi Kasama
Assemblywoman Susie Martinez
Assemblywoman Elaine Marzola
Assemblyman P.K. O'Neill
Assemblywoman Jill Tolles

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27

STAFF MEMBERS PRESENT:

Marjorie Paslov-Thomas, Committee Policy Analyst
Terri McBride, Committee Manager
Julie Axelson, Committee Secretary
Cheryl Williams, Committee Assistant

OTHERS PRESENT:

Kate Ballard, Private Citizen, Portland, Oregon
Dave Wuest, Executive Secretary, State Board of Pharmacy
Amy Koo, Deputy Political Director, One APIA Nevada
Tamara Telles, Private Citizen, Gardnerville, Nevada
Barry Gold, Director, Government Relations, AARP Nevada
Christine Saunders, Policy Director, Progressive Leadership Alliance of Nevada
Gillian Block, representing Nevada Coalition of Legal Service Providers
Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District
Dora Martinez, representing Nevada Disability Peer Action Coalition
Diem Nguyen, Health Navigator, Asian Community Development Council
Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada
Graham Galloway, representing Nevada Justice Association
Nick Vander Poel, representing Reno + Sparks Chamber of Commerce
Paul Moradkhan, Senior Vice President, Government Affairs, Vegas Chamber
Bryan Wachter, Senior Vice President, Government and Public Affairs, Retail Association of Nevada
Julia Peek, Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services

Chair Jauregui:
[Roll was called.] We have two bills on our agenda today. I am going to start with Assembly Bill 177, and I will open the hearing on Assembly Bill 177. I believe we have our Majority Leader, Assemblywoman Teresa Benitez-Thompson along with her copresenter Ms. Kate Ballard.

Assembly Bill 177: Revises provisions relating to prescriptions. (BDR 54-61)

Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27:
I want to give you a little bit of history on how we got here. Why do we need a bill like Assembly Bill 177? Why are prescriptions not available in multiple languages so people with limited English proficiency can readily know what is in their prescription bottle, and how they should take it? In his paper, "English is not Enough: The Language of Food and Drug Labels," Ryan Arai details the history of the Food and Drug Administration (FDA) English-only policies. In his paper, Arai looks at demographic trends in America and contrasts it with the FDA's food and drug label requirement that labels be printed in English with no consideration for translation into additional languages. He notes some exceptions to the rule for Spanish-speaking United States territories. He also recounts that the FDA did experiment with Spanish language translation requirements for patient package inserts in 1980. Patient package inserts, which are required to accompany a prescription drug, were developed for four reasons: (1) to promote the safe and effective use of prescription drugs; (2) to provide patients with the benefit, risk, and directions for use of the prescription drugs; (3) to reduce potential liability for prescription drug manufacturers; and (4) to reduce the

number of overall malpractice actions for physicians. These are all good things. However, the FDA revoked the requirement for patient inserts to be printed in Spanish just two years later. Policy has been relatively static ever since.

Under the status quo, health care facilities receiving funding from the federal government, including Medicaid and Medicare reimbursements, should provide interpretation and translation services to individuals with limited English proficiency. For example, the Civil Rights Act of 1964, the Americans with Disabilities Act, and the Affordable Care Act are federal laws that require hospitals, clinics, and other health care institutions covered by federal funding to provide language access. However, these are commonly interpreted to mean verbal translation while inside the clinical setting and have been implemented as such, including in pharmacies.

Here is the problem. The problem is that persons with limited English proficiency are systemically prevented from having their prescription labels and patient information printed in a language they can understand. The composite of our nation is changing to be a majority minority nation, and Nevada's demographics reflect that national trend. According to the report, "Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections 2000 to 2038: Estimates from 2000 to 2017 and Projections from 2018 to 2038" [Exhibit C], prepared by Jeff Hardcastle, the Nevada State Demographer with the Department of Taxation, states that the Nevada population right now in the year 2021 is just over 3.1 million people. There are 320,000 Asian or Pacific Islanders not of Hispanic origin, which is 10 percent of the total population. In addition, 977,000 are of Hispanic origin of any race, which is 31 percent of the population. The trends are projected to grow, and by 2038, Nevada's population will grow to just over 3.5 million people, of which nearly half will be Asian or Pacific Islander, and 1.3 million will be Hispanic.

What do we know about the ability for these populations to have English proficiency? We have data on that too. It does not have to be a guessing game. On March 9, 2020, the Guinn Center for Policy Priorities' Daniel Liden published "The 2020 Census in Nevada Snapshot #7" [Exhibit D]. It states, "There are 139 census tracts in Clark County, most of them located in Las Vegas, wherein more than 10 percent of households have no residents over the age of 14 who speak only English or who speak English 'very well' . . . ." At this point, I am going to screenshot a piece of that report for you because I think it is important to see what we know about languages in Clark County, specifically. You can see here in "TABLE 1: TOP LANGUAGES SPOKEN IN CLARK COUNTY AND PERCENTAGE OF SPEAKERS OF THOSE LANGUAGES WHO SPEAK ENGLISH LESS THAN 'VERY WELL,'" of Spanish, we have 45 percent; Vietnamese, 57 percent; French, 18 percent; and German, 15 percent [page 3, Exhibit D]. These are our folks who are less than English proficient and do not speak English very well. We can see right now that of these populations, they would not be comfortable picking up a label and reading it. These are the folks who absolutely need language assistance.

The data population trends such as these help us understand the changing face of Nevada. Ideally, these trends are ones that many industries are watching and planning for, including the health care sector. Why? It is the right thing to do for patient safety. As part of the literature review and study, "Evaluation of Language Concordant, Patient-Centered Drug Label Instructions," the lead author, Stacy Cooper Bailey, Ph.D., MPH, states, "Recently, studies among LEP adults have linked Rx misunderstandings to higher rates of drug adverse reactions, unsafe medication management and poor adherence." Additionally, the Institute of Medicine reported that poor comprehension of prescription instructions is a root cause of adverse drug events and other medication errors. It makes financial sense for the entire health care system. Adverse drug events are very costly to the medical system, and many of them are preventable. The study, published by Pharmacoepidemiology and Drug Safety, "Identifying hospital admissions due to adverse drug events using a computer-based monitor," from the official journal of the International Society for Pharmacoepidemiology, found that as many as 28 percent of adverse drug events are preventable, and severe events trend toward being the most preventable.

I would propose a solution to all of this is a public policy change that is embodied in A.B. 177. It is a surprisingly short bill, but as we all know, short bills can be the ones that cause us the biggest amount of angst and be the ones we need to give additional consideration for all types of consequences from them.

In section 1, under *Nevada Revised Statutes* (NRS) 639.2801, you are going to see the requirement that the prescription label could be printed in a language other than English in addition to the English label. Remember, because of the FDA's English language policy, you must have an English label on that bottle, so it would be an English label and a label in the language the person is proficient in. You will also see in section 1, subsection 2, we are looking for the pharmacy to publish a notice with the list of languages they can print in that says patients can ask for their prescription label to be printed in an additional language.

You will also notice some requirements for the State Board of Pharmacy and the type of regulations they will have to adopt and bring into place. You will hear testimony from those in opposition to section 1, subsection 5, and we are having an ongoing conversation regarding that. I think we are going to end up in a good place.

There are two pieces of the bill that I want to make sure you know I am going to be working on with stakeholders. The first is on section 1, subsection 1, where the requirement is English and any other language. Instead, I am looking to conceptually amend this based on demographics within a given area. That way we will not have an ambiguous regulation where the label can be printed in all languages known in the world, but rather what is happening within the state or a specific area of the state. We can be more targeted in the languages that are available. I already told you about section 1, subsection 5, where there is conversation on that. The second is for the notice of the patient rights. It seems to make the most sense to have the Board adopt what the standard languages would be by using demographic data for the languages that should be posted in the pharmacies so people know of their right.

Lastly, I want to say that one of the biggest reasons I feel like this public policy should be considered, and hopefully passed, is because we know people go home with their medications once they leave that supportive clinical setting. We have so many families who are looking at that bottle and cannot read or understand it. For all the same reasons we want any type of health care information to be out there, and all the reasons the FDA put patient inserts in place to prevent adverse drug events, they are useless if you cannot read them. They are useless if you have a family sitting in a home trying to Google Translate how to apply a fentanyl patch or how to use their morphine bottles. As a person who has worked in health care for the past ten years in a home-based setting, meaning being in individuals' residences, I have left homes so many times, after working with families who have limited English proficiency, wondering how they were going to understand how to use their prescriptions with changing caregivers. You cannot tell one person in a family and assume the onus is going to be on them, their children, or extended family members to translate all of this. It needs to be medically certified translators doing that. This has kept me up a lot at night, worrying about those kinds of families. That is why I appreciate the time to discuss this piece of legislation. I will now turn it over to Ms. Ballard.

Kate Ballard, Private Citizen, Portland, Oregon:
I am a registered nurse in Oregon. I was one of the primary advocates for a very similar law in Oregon, Senate Bill 698, that was passed in 2019 and went into effect January 1, 2021. The Oregon law came about after nursing students, working with patients with limited English proficiency, noticed a high rate of medication error with this population. For example, there was a mother from the Middle East who was highly educated and spoke multiple languages, but English was not one of them. She could not read the labels on her child's inhalers and was unintentionally giving him the wrong inhaler during his acute asthma attacks. This child was hospitalized for life-threatening asthma attacks that were unknowingly going untreated.

After this bill was introduced to the Oregon Legislature, there was an outpouring of support. The commonsense legislation resonated with health care professionals, community organizations, and private citizens alike. Simply put in one testimony, the only difference between a medicine and a poison is understanding how to use it.

I would like to briefly address some of the common questions about prescription translation bills. First is cost. In analyzing the financial impacts of A.B. 177, it is important to consider the significant cost savings this bill would bring. A large portion of the costs projected by chain pharmacies are front-loaded costs to integrate the translation software into their complex systems. This is marginal compared to the high, ongoing cost of treatment for medication errors or noncompliance. The average cost of a single hospitalization for a preventable medication error is $15,000, which totals in the billions of dollars each year nationally. Experts on health care economics agree that the costs from language-related medication errors will continue to increase over time unless health care providers meet demands for improved translation services. Furthermore, chain pharmacies have both the time and necessity of integrating translation software. New York passed such laws in 2009.

Second is safety. Certified translation companies use a rigorous multistep vetting process in their translation of prescription labels. One example of the vetting process is: (1) translation by a native-speaking linguist with the appropriate medical background; (2) editing by a second individual with the same qualifications; (3) back translation into English by a separate team; (4) reconciliation between the original and back translation to resolve any discrepancies in a final translation; and (5) final medical linguist review of the translation. The risk of a medication error is far lower than sending a patient home with a prescription bottle in a language he or she cannot read or understand. In addition, A.B. 177 provides protection to pharmacists using certified translation companies. They cannot be held liable for a translation error.

Third is dual labels. Dual language labels ensure that patients with limited English proficiency and their English-speaking pharmacists, caregivers, and providers know what the prescription label says. Here is an example [showed a prescription bottle from Oregon labeled in English and an additional language]. The instructional phrase is called a "sig," such as take one tablet by mouth daily. Here is the English sig, and here is the translation. For this bill to be effective, the translated sig must be on the bottle, not in a supplemental packet. The reality is that many patients have upwards of five medications plus kids with medications of their own. It is not realistic to expect a patient to keep track of five or more instruction packets then match the correct packet with the correct medication bottle. If the translated sig is not on the bottle, the safety of Nevadans will continue to be at risk. The intent of the bill is that the sig that ordinarily goes on the bottle in English must also go on the bottle in the translation. Both the English and translated sig will fit on a normal sized bottle in most situations. However, there are several options to address uncommon situations where extra room is needed, including pull out tabs or folding a second label in half and sticking it to the bottle, which is a common practice that pharmacists use, called flagging.

Fourth is laws in other states. Currently, Oregon, New York, and California have laws governing translation of prescription labels. I urge your caution in considering the California law which is extremely limited. It only mandates that a specific list of 15 sigs be translated into just five languages, and it allows pharmacies to put the sig in a supplemental packet rather than on the bottle. These unsafe standards would completely undermine the effectiveness of A.B. 177. In contrast, the Oregon law requires that all sigs be available in at least 14 languages and that the translation must appear on the bottle. Like Oregon, Nevada can certainly do better to protect its residents.

It is in a pharmacist's code of ethics to communicate with patients in terms that are understandable and to respect personal and cultural differences among patients. Thank you for your consideration, and I am willing to answer any questions you may have.

Chair Jauregui:
We will now go to the Committee members for questions.

Assemblywoman Dickman:
I think this is important, but I do have a couple of questions. In your chart, I think I counted 12 languages. Is that what we are looking at to translate?

Assemblywoman Benitez-Thompson:
In section 1, subsection 3, it says, "The Board shall adopt regulations prescribing . . ." and then goes into the languages in which the pharmacies are required to provide the information. In other states, they have taken the approach of setting a hard-and-fast number in statute; I do not think that is the best policy. Instead, it makes the most sense to look at our demographic data and projections and ensure we are serving the community as the data shows us the composite of the community. The best legislative goal would be to allow the Board to look at those demographics and data and then make a decision from there on the number of languages.

Assemblywoman Dickman:
In Washoe County we would not need 14 different languages, correct?

Assemblywoman Benitez-Thompson:
Again, I want to defer back to what the data and demographics are going to show us and how our population is growing. I think that way you write a policy that does not have to come back and be updated every decade. You have a law that is more amenable to our communities as they change.

Assemblywoman Dickman:
Ms. Ballard talked a little bit about cost and what the cost would be if we do not do this. Do you have a rough idea about what it might cost to implement this, and who absorbs that cost? Would it be the pharmacy?

Assemblywoman Benitez-Thompson:
Right now, as the bill is written, it is a requirement for the pharmacy to enact this. They would have the label in English. I am going to let the Board speak for themselves about their capability. I do not think they would be comfortable with me speaking for them. I can tell you what I have heard in different conversations about what they can and cannot print, but it would be about the pharmacies ensuring the ability to translate the label.

Assemblywoman Dickman:
Would they be absorbing the cost for software and whatever they do?

Assemblywoman Benitez-Thompson:
I have been talking with one FQHC [Federally Qualified Health Center] locally. They let me know that with the software translation service they use, it would be an additional $50 a month for them to get access to 50 more languages. Another reason I do not think we want a static number in statute is because we do not want to force people to purchase

more languages than they have to. Some other systems have told me it would be $12 million. I have been open about trying to find a way to reconcile the wide ranges that people are talking about from $50 a month to $12 million.

Assemblywoman Dickman:
May I have a follow-up?

Chair Jauregui:
I will go to other members first, and then I will come back to you.

Assemblywoman Carlton:
There were some terms that were used that I want to make sure I understand. We were talking about medically certified translators. Whenever I want to put out something in multiple languages, or if I try to put up notices in multiple languages, there are so many different dialects. Sometimes it means one thing if someone is from a certain area in South America versus someone from Cuba or someone from Mexico. I want to understand the term "medically certified translators" because there are so many different dialects that I would hate to have the wrong translation out there. If the translation does not end up being correct, who is actually held responsible? I need to understand a little bit more about the software and what these certified translators are and if that is the safety valve to make sure things are translated correctly.

Assemblywoman Benitez-Thompson:
I will answer that and then let Ms. Ballard answer as well. Medically certified translators are required if you are in a clinical setting. For example, if you work in a hospital, although you might be a native speaker of a language, you are not allowed to translate unless you have that certificate of translation that shows you have taken the courses and passed the test. As another example, I can speak conversational Spanish, but I am not fluent in Spanish, and I am not a certified translator. When you are in those clinical settings, most of them will have a toll-free number that you can call to get access to translation services, and that is all verbal. That is the piece we were talking about with the Civil Rights Act of 1964 and the Affordable Care Act. That is what we mean by "medically certified" and "third parties."

As for the terms of responsibility for not having accurate translation, I will let Ms. Ballard talk about what medical translation looks like specifically, but I will say that I am having ongoing conversations with the Nevada Justice Association. We will hear testimony from them about parity between the laws and liabilities around verbal translation and this bill, which has a written translation, and their arguments as to why the written translation should have the same protections as verbal translation. I will let Ms. Ballard talk a little bit more about that medical translation piece.

Kate Ballard:
As for the accuracy of the translations, in my testimony I did go over the step-by-step process. To address your question more specifically, the differences in dialect should be identified in that vetting process where it is reviewed by independent groups and individuals.

Where one translation is created, that vetting process is then reviewed by an independent group of individuals. Hopefully at that point, those slight differences across geographies would be weeded out. This is the same rigorous process that is already used for verbal communications as well. I hope that answers your question about differences in dialect. As well, I will say that we have learned that sometimes differences in dialects are not reflected in writing. Does that answer your question?

Assemblywoman Carlton:
I will follow up about the software. Since Majority Leader Benitez-Thompson is getting so many different opinions on what the software costs, and this has been done in your state, do you happen to know how much the software costs the pharmacies in your state? Were you able to ask any of them what the real cost of doing business is?

Kate Ballard:
As was mentioned before, it varies widely depending on the kind of software the pharmacy or health care system already has. For chain pharmacies that have multiple locations and already have very complex, expensive software, it can be more expensive to integrate it. However, for one large hospital system in Oregon, it costs them $25,000 to translate 1,000 sigs and have an automated set up where it automatically pulls from the chart what language the patient speaks. It does not even have to be requested and it spits out a translated label. For 1,000 direction phrases, it costs $25,000. However, for an independently owned pharmacy in Oregon that provided translated labels before the law even went into effect, it cost them $70 a month for 14 languages. There was another company in Oregon that would provide 100 sigs in one language for a $250 one-time payment. Those are some of the examples.

Chair Jauregui:
I have a quick question. When we were speaking about the costs in Oregon, do you have any hard data you can share with us on if this has helped reduce the number of misuses of prescriptions?

Kate Ballard:
I wish I had more hard data. It has only been three months since the law took effect, so, unfortunately, I do not have hard data compiled. I will say that in my personal opinion as a nurse, I feel much more confident being able to discharge patients from the hospital with a label they can read.

Assemblywoman Benitez-Thompson:
I imagine that the data will follow because there is the federal language law and mandate. We are just starting to see what is a very exciting movement around language equity in this space. We are starting to have these conversations about the health information and prescriptions. You will notice in my opening testimony, I referenced five or six studies. In talking with the committee manager, some of the studies were copyrighted, so I was not able to present them as exhibits to put the data information in your hand. Instead, I had to cite all the sources in my testimony. There are five different studies regarding adverse drug

effects and the link to language. I have been working with your committee manager about which ones we can have as exhibits and which ones will have to be paper copies that are circulated to you.

Assemblywoman Hardy:
What currently happens for non-English-speaking patients when they go to the pharmacy? Usually when you go to the pharmacy, you will have a consultation with the pharmacist who will explain the prescription. If the pharmacist cannot communicate with the patient, do they just hand them their bag and off they go?

Assemblywoman Benitez-Thompson:
If you have ever walked into a pharmacy, you never see pharmacists sitting down. They are so busy, they are doing so much, and they care. I do not believe they would just hand off the bag. While at the pharmacy, they are required in that setting to have translation services. They will have a toll-free number available so they can translate at that time with that person. Where this bill becomes important, and where the difference is, that currently, once the patients walk out that door and are in their homes, they are left with nothing in their own language and without the ability to have translation services at hand. That is the distinction we are trying to get to in making sure this information follows the patients into their home.

Assemblywoman Hardy:
As you mentioned, several states are starting to do this. Is this bill based on the Oregon law?

Assemblywoman Benitez-Thompson:
This bill is specific to Nevada in that we are just looking at NRS 639.2801. If you look at NRS 639.2801, there are nine data points that the Board of Pharmacy requires to be on the prescription label. We are asking for that to be translated into different languages. Ideally, and if it were the will of the Committee, I would love to see more information translated. It sounds so simple, but if we get just the label done, we are in a great place for our citizens. That is how it is a uniquely Nevada bill. This bill came to me because I was talking with friends over the summer about the frustration in the role that I have as a professional social worker in the medical field and working in people's homes. I felt as though I was not serving them best because we have so many language issues. Someone said it does not have to be that way. They have done something about it in Oregon and California, so we got in touch with Oregon. I do not want anyone to think this was me raising my hand saying I want to do something that is done outside of Nevada and bring it here. That is not me. I am the first to say if Florida jumped off a bridge, should Nevada jump off a bridge? It came to me because I verbally put it out in the universe about my level of frustration and concern for people in the home.

Assemblyman O'Neill:
Ms. Ballard, I want to clarify and build upon what Assemblywoman Carlton said. Did you say the liability for the translations is assumed by the pharmacy and not the translation company?

Kate Ballard:
No, the bill provides liability protection for pharmacists who are acting in good faith and contract with a certified medical translation company. If they do that, they cannot be held liable for a translation error.

Assemblyman O'Neill:
That is how section 1, subsection 5, is written now. I agree with you, and that is the way it should be. Liability should be on the person who did the work. Also, you said this has only been in effect for three months in Oregon so you probably cannot answer this, but did this increase the cost of any medications? We already complain about the high cost of medications, so has there been any increase in cost?

Kate Ballard:
No, not that I have observed; there has been no increase in cost. I know it was the intention of the legislators and representatives in Oregon who championed the bill to ensure it did not raise the cost of medications. The pharmacies and various stakeholders we worked with throughout that process ensured us that would not occur. I cannot speak for Nevada specifically, but I would imagine it will not.

Assemblyman O'Neill:
I like the intent of this bill because we are here for the betterment of our citizens and to improve health care. This is one aspect of how we can improve health care, and I think it is an excellent bill to do that. If I understand the process correctly, when the foreign language speaker comes in, there will not be a delay in getting him or her the medication. The pharmacist would go to the computer and request it to be translated into that language, and it comes out immediately. The pharmacy does not have to delay the delivery.

Assemblywoman Benitez-Thompson:
We have an FQHC that does this locally, and it is done with the click of a button.

Assemblyman O'Neill:
I wanted to make sure I had it correct. We are here to try to improve health care, so I wanted to make sure there was no delay.

Assemblywoman Considine:
I want to ask a question that other people were maybe trying to get to, or maybe I was just going there myself. I understand the lives and health that are being saved by being able to look at your prescription bottle and read it in your own language to make sure you are taking it the correct way. I can see the savings there. In the three months since Oregon has enacted this law, have there been any pharmacies that have refused to do this or closed down? Was there any kind of significant force to stop? Are people able to do this to help folks get their prescriptions and be able to read them?

Kate Ballard:
So far, I have personally seen good success with pharmacies in Oregon. While we were creating this bill, the Oregon Board of Pharmacy said the way they approach compliance is that they do not take a punitive approach but try to work with pharmacies toward compliance and understand the obstacles they face. As for Nevada, I cannot speak for the Board of Pharmacy there. I will add that independently owned pharmacies typically face more conservative costs with this bill. Does that answer your question adequately?

Assemblywoman Considine:
I think it does. You have not seen any pharmacies close? It is just a matter of maybe there is a time to ramp up or get accustomed to it?

Kate Ballard:
Exactly. To my knowledge, I have not heard of any pharmacies closing down. I am sure I would have heard about it if it had happened.

Assemblywoman Benitez-Thompson:
As written right now, in section 2, the effective date is upon passage and approval. I would be more than willing to talk with stakeholders about the regulation part. Typically, we can say passage and approval starting the regulations and then give a year for that to happen. Then the time to start for the pharmacies to have to take action—I do not know if we have gotten to section 2 in conversations. That is something we want to be sensitive to. If we asked people to turn a switch tomorrow, it might be pretty costly, but if we looked and made sure people had time to start exploring vendors or system operators, they would have that time.

Assemblywoman Kasama:
I love all of the explanation and presentation and how it would be helpful for everybody. I can certainly see that. I did not realize that if somebody goes into a pharmacy right now in the state of Nevada, there is an online translation service if they need help in translating the prescription. Is that correct?

Assemblywoman Benitez-Thompson:
You do not mean Google Translate?

Assemblywoman Kasama:
I thought you said that if somebody goes into a pharmacy in Nevada there is an online translation service if they need help with translating their prescription. Is that correct?

Assemblywoman Benitez-Thompson:
It is a phone call. When you are talking with your pharmacist and if you were not language proficient, per the Affordable Care Act and Civil Rights Act of 1964, the pharmacist would call the translator to have a conversation with you.

Assemblywoman Kasama:
I see. The person getting the prescription translated can take notes in his or her language as to what should be done and go home with that?

Kate Ballard:
They could perhaps do that. Although in my practice, I have not seen that done. Sometimes, in-person interpreters are willing to write out translations, but that is dependent on the individual's preference. I will also say that now, especially during COVID-19 times, I have seen there has been a huge increase in virtual or phone interpreters being used. The interpreter would not be there to write things down for them. Orally, there is always the potential for mistakes to happen when it is going from one person to another, and that person is writing it down. It is much safer to just give them the translated instruction that has been vetted.

Assemblywoman Kasama:
I can see that it might be better to have it written. I am just concerned about the cost that goes to these pharmacies and the requirements. I know my parents were immigrants who did not speak English, and they had a lot of trouble with things like this, renting a house, and filling out forms. They got help from the community and rallied. It was not easy, but those were some of the steps they took. I understand the intent, and it is good, but I am just concerned about the cost being added to it.

Assemblywoman Tolles:
Certainly, communication is key in making sure people understand what it is they are taking. This is important for all the reasons you outlined. Has the Board of Pharmacy had a chance to review this language and run it by their members and get feedback because we are hearing so many different levels of estimates of cost and questions around implementation? Did the Board have a chance to weigh in, or are they available to weigh in?

Assemblywoman Benitez-Thompson:
I believe they are on the call. I will let them represent themselves.

Chair Jauregui:
Yes, I believe we have Dave Wuest with the Board.

Dave Wuest, Executive Secretary, State Board of Pharmacy:
Can you repeat the question so I can make sure it is clear to me?

Assemblywoman Tolles:
I wanted to see if you had any input as to whether you have consulted with other boards of pharmacy in other states that have implemented this and learned how the implementation was, and how you envision the implementation here in Nevada may go? Have you surveyed the members in Nevada and what the possible costs will be? I want a more clear, overarching answer.

Dave Wuest:
I am familiar with the bill. The concept of the bill would be that people would be able to communicate with each other which of course is the right way forward. We want people to understand. Pharmacists do have an obligation to counsel the patients and they use several different mechanisms, one of which would be by telephone translators. The bill in Oregon is relatively new, so I put a call in to the Oregon Board of Pharmacy, but I did not hear anything back. You heard from Ms. Ballard that it is still in the implementation process. As far as the cost goes, I think you will see it is wide ranging. If people do a simple fix, it will not be that expensive. When you are [unintelligible] multimillion-dollar systems, that might be more expensive. The Board feels that we work for you, and if you implement a law, we will make it work one way or another.

Assemblywoman Tolles:
I love the intent, and I hear the concerns. I am wondering if there is a way to consolidate. Perhaps I could take this offline with the sponsor to discuss how to accomplish this task in a way that will help with cost-saving concerns by having one consolidated statewide source where you could get that translation printed out and still accomplish the same goal that we are trying to accomplish here. That is something I can take offline. I am just trying to address the concerns that have been raised while still accomplishing the goal because I think it is a good goal.

Assemblywoman Dickman:
I am still on the liability. I know we touched on it, and I believe Assemblywoman Benitez Thompson said you are still working on that. Currently, if you get your prescription in English, and it is incorrect, you have some recourse. I hate to use the word sue, but there are protections in place. Who is liable? We have to protect this patient too. You made it clear that the pharmacy would not be liable, but would the translator be liable?

Assemblywoman Benitez-Thompson:
You are going to hear from the Nevada Justice Association in opposition later because of that subsection. They obviously know law and liability more than I do. We have been able to talk a little bit, and it is my understanding they are going to talk about the parity they would be seeking between verbal translation and written translation. It is an argument I am open to. That is why liability is a work in process.

Assemblywoman Martinez:
This would be most helpful and useful so a person could go home and read that information from the prescription in the privacy of his or her home. I think our prescriptions are very private, and we do not want everybody to know. I would not really want to take it to my neighbor and let them know what my medical needs are. Some things are very private. By them being able to take this home, this would make it more private and very useful, would it not?

Assemblywoman Benitez-Thompson:
Absolutely. My experience has been that patients do not want to do one main thing, which is appear to be a burden to their family or to anyone. This kind of manifestation of toughness means we do not often ask questions or ask for help. I do not necessarily have data on it, but I think there is a sensitivity to what some of these prescriptions are, and people of limited English proficiency would rather be able to read them and be in charge of their own health care by being empowered by a simple act of reading the information in a language they can understand.

Assemblywoman Martinez:
I agree.

Chair Jauregui:
We are going to move to testimony. We do have another bill to hear after this, and some members have other committees they need to be on. I will be limiting testimony on both bills to 30 minutes in each category, which is 30 minutes in support, 30 minutes in opposition, and 30 minutes in neutral. With that, I am going to move to support of A.B. 177.

Amy Koo, Deputy Political Director, One APIA Nevada:
I want to thank Assemblywoman Benitez-Thompson for centering language access in health equity. Nevada is home to over 300,000 Asian/Pacific Islander Americans, comprising about 10 percent of the total population. We focus on the issues that affect our livelihood, including language access and health care. As the fastest growing community in Nevada, we are aware that the infrastructure to support the community is lagging. I have been a translator for my parents for as long as I can remember. Like many second-generation children, my parents relied on me to fill a gap in language access in our institutions. When my parents would have changes in medication or need to read dosage instructions, they relied on me to ensure they were taking it correctly.

There are approximately 300,000 limited-English-proficient Nevadans who are also facing these barriers to health care. For new immigrants and mixed-fluency households, having prescription instructions in both English and their native language is a critical step to ensuring health care parity for all Nevadans. Currently, about 1 out of 5 emergency room visits is due to a preventable medication error. One case of a mistaken medication can cost up to $10,000 in hospital fees.

In New York state where a similar translation bill for prescription labels was passed in 2012, we saw that from 2006 to 2015, there was an increase in pharmacies that reported translating labels daily from 15.4 percent in 2006 to 66.7 percent in 2015. This is a great opportunity to advance language justice in Nevada, and A.B. 177 is a cost-effective and critical step to ensuring all Nevadans have health care parity.

Tamara Telles, Private Citizen, Gardnerville, Nevada:
I am a public health diversity advisor in health sciences at the University of Nevada, Reno. Last year, my team and I conducted a study and found a need for improved Latinx

communications, especially around health and with the pandemic. A couple of key findings from that research was that the lack of good communication in translations creates additional barriers to care and increases a burden of disease in Nevada. Also, using online translation tools such as Google Translate does not always translate things correctly and, therefore, are not reliable from English to Spanish or any other language for that matter and creates more disparities. With that being said, I support this first language health services because this is a simple change that can really create a huge and positive impact.

Per the 2019 Nevada State Health Needs Assessment, over 30 percent of Nevada's population is Latinx, and it is the population that continues to increase the most. For many, English is their second language. In addition, the immigrant share of the population is near a historic high according to key research. Nearly half had limited English proficiency. This bill would not be depleting any other health services where creating other health services would be more expensive and SNAP [Supplemental Nutrition Assistance Program] intensive. There are many different disparities in the Latinx communities. One is that translating is too technical and sometimes too risky for family members and friends. Many children are the translators for their parents, and children should not have to be relied on to read prescriptions. Prescriptions can be challenging just in English.

Other types of health navigator services would also be more expensive and are not 24/7 with nurse navigators and community health workers. This would really make a big difference. Health and language equity are really important, and everyone has the right to be served in his or her first language. Again, reading prescription labels is challenging enough, and I cannot imagine trying to translate my medication from one language I am not confident in and trying to consume that as well.

Barry Gold, Director, Government Relations, AARP Nevada:
This appears to be very simple public policy, but this has and will have a huge impact on improving public health. Many of you have heard me use the old saying that lifesaving drugs do not work if you cannot afford to take them. You can also say lifesaving drugs do not work if you do not know what they are or how to take them. Nevada passed a bill several sessions ago that said you can put the reason or symptom for the drug you take on your pill bottles. For example, Pantoprazole for heartburn or GERD [gastroesophageal reflux disease]. If you cannot read what that label says, that is not going to help you.

Individuals, family members, and caregivers who often assist people with taking their medicines really need to be able to understand what the prescription drugs are and how to take them. We heard earlier that the average person takes about five prescription drugs. If you are going to talk about older adults, it is very often they have ten or more prescription drugs. How many of us have walked into our grandma's house and seen a table full of prescription drug bottles? There could be 10, 15, or 20 bottles, and she has no idea what they are. If she cannot read what is on them, that is even worse. We really need to have some way to make this a little better. AARP Nevada, on behalf of the 345,000 members, strongly supports the passage of A.B. 177. It is really going to help Nevadans have better health outcomes if they are just able to read their prescription bottles.

Christine Saunders, Policy Director, Progressive Leadership Alliance of Nevada:
I am here in support of A.B. 177. This bill is a simple solution that will address a discriminatory practice that leaves many Nevadans unprotected at a time when they are most vulnerable. It is a vital step to save our patients, reduce long-term costs, and provide language justice for Nevadans. We urge your support.

Gillian Block, representing Nevada Coalition of Legal Service Providers:
I am speaking in support of A.B. 177. We are in support of the effort to make prescription drugs legally more accessible to the low-income community members we serve who primarily speak a language other than English. [Unintelligible] Alliance sets consumer protection goals to ensure the people have meaningful access to the important information they need to make critical decisions.

Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District:
We are here in support for this important bill. We believe it is common sense and takes an important step toward closing the gaps in health disparity. We urge your support for A.B. 177.

Dora Martinez, representing Nevada Disability Peer Action Coalition:
We support A.B. 177. I would like to emphasize the population who are American Sign Language (ASL) speakers to keep you aware that they do not read English. Their first language is ASL. Some of you are not aware of this, and that needs to be put in somewhere so they can have equal access to medications.

Diem Nguyen, Health Navigator, Asian Community Development Council:
[Read from written testimony, Exhibit E.] I have lived in Las Vegas for seven years, and I have worked with the Vietnamese community across the state to enroll them in health insurance. I am testifying in support of A.B. 177. We know there are 68,000 limited-English households across the state. The Asian Community Development Council is a partner of Nevada Health Link, and we have bilingual staff in Tagalog, Vietnamese, Chinese, and Spanish. We are passionate about health care parity and language access. [Audio was lost.]

Chair Jauregui:
If you have your statements written, please feel free to share them with our committee manager so she can make sure the Committee members receive them since we keep losing your audio.

Diem Nguyen:
The small Vietnamese community in Sparks has to use Google Translate to read patient information. [Audio was lost.] Do I send my information by email?

Chair Jauregui:
Yes, if you can send in your written remarks [Exhibit E] via email to our committee manager, we will make sure we post them as an exhibit for this bill and share them with the Committee.

Diem Nguyen:
I think that is better. I am so sorry that my Internet is so terrible.

[Letters in support, Exhibit F, Exhibit G, Exhibit H, and Exhibit I were submitted but not discussed and will become part of the record.]

Chair Jauregui:
Thank you for being a part of the process and participating. With that, we will move to testimony in opposition of A.B. 177.

Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada:
I thank the sponsor for the work that has been done so far. The Retail Association of Nevada is proud to represent many of the community pharmacies in Nevada. A pharmacist is one of the top three most trusted professions for many years now. They are accessible to patients and taking care of the patient is something they take very seriously. Our members are proud of the services they offer every Nevadan in the community they serve. This is true inside their physical locations as well as going out to different locations within the community. They have been doing a super job.

Community pharmacies stand ready to serve our community health needs daily and during times of emergency. These pharmacies include the traditional drug stores, supermarkets, mass merchandisers that have pharmacists, as well as our independents, which we have only a few of in Nevada.

The Retail Association of Nevada members believe in including every citizen, group, or community in Nevada in taking care of their health care needs. Assembly Bill 177 seeks to mandate pharmacies affix two different labels to the prescription drug bottles, one of which must be any language requested by the customer, and at this point in time, the language reflects that. The members understand the needs of the communities that this bill intends to assist and have been working for years to try to provide such service for them.

Retail pharmacies recognize that not all customers are fluent or prefer to use English in their daily lives. Because the primary language of medicine is English, many terms and instructions do not easily translate, and we believe the verbal consultation with a certified translator is the gold standard that allows customers to have a complete understanding of their medication and how to use it safely and effectively. There are directives in the store that pharmacists are always there to help that patient who may not be an English-speaking patient. They will guide them to the toll-free number for a better understanding of the direction of the medications. Anyone can call this number at any time. Any family member within the home has access to this number to get the translation if there is no understanding, and the patient can also call. It is a 24/7 number. There is always someone there. We have the same translators as hospitals, and we provide it outside of clinical settings also.

Public health and pharmacies have a strong history of reaching mutual public health goals together for the benefit of all patients in our state. We appreciate the sponsor adding the third-party liability to the language, and removal of that language would raise even more concerns for our members at this time. We would like the opportunity to work with the sponsor of the bill and to improve services to every community in Nevada, specifically minorities and those with limited English-speaking skills. The Retail Association of Nevada believes we need to have further discussions with stakeholders as we have concerns and oppose the language as it is written today. We would like to thank the sponsor for engaging those in the industry and look forward to working with her as we go forward. I will be happy to answer any questions.

Graham Galloway, representing Nevada Justice Association:
We are generally supportive of this bill and think it is a good bill. We think it establishes good public policy, but we do have some difficulties with the immunity provisions set forth in section 1, subsection 5, of the bill. Therefore, as a formality, we are opposed to it as the bill is presently set forth. We would be fully supportive of the bill if it was amended in the matter of removing subsection 5, the liability section.

Immunity is a difficult concept for the Nevada Justice Association, particularly as you look at the last special session where huge grants of immunity were established. Immunity restricts access to the court and undercuts holding people and entities fully accountable and responsible. If you excuse people's bad conduct, all you do is encourage a lack of diligence. Immunity has unintended consequences. In this bill, if you leave this immunity provision in, you establish two classes of individuals, those who speak English and do not have to deal with any immunity issues, and those who do not speak English who then have to deal with immunity issues. From the constitutional law perspective, I think that raises unintentional equal protection consideration or equal protection argument. We appreciate the conversations with the sponsor of the bill and the opportunity to continue to work with the sponsor. We are hoping that the amendment we have suggested, eliminating section 1, subsection 5, will be considered, and ultimately, our opposition will turn into a position of support.

Chair Jauregui:
Is there anyone else wishing to testify in opposition?

Nick Vander Poel, representing Reno + Sparks Chamber of Commerce:
I am here to oppose A.B. 177. While we appreciate Majority Leader Benitez-Thompson's valiant effort, we must point out that these individuals who request interpretation have access to various options that were imposed by the Affordable Care Act. Further, during a time when pharmacies are overrun by pandemic-related issues, including vaccination appointments, it seems overly burdensome to require that international language accompany a prescription. We know we have limited time to testify in opposition, but we did submit a letter [Exhibit J] detailing our opposition that shares some of the same concerns that were outlined by our colleagues at the Retail Association of Nevada. While this bill is well-intentioned and recognizes our increasing diversity and appreciation for its growth, we

oppose this bill due to its stringent burden on pharmacies and those employees who want only to assist their customers in an efficient manner.

Paul Moradkhan, Senior Vice President, Government Affairs, Vegas Chamber:
The Vegas Chamber does have concerns with the bill as proposed on behalf of our members who would be directly impacted by these proposed changes. We agree that prescriptions should be available in other languages if requested by the customer. However, as you heard from my colleague from the Retail Association of Nevada, pharmacies do print instructions in a variety of languages and offer customers further assistance with that toll-free language helpline. We are concerned about the cost that would be associated with the requirement to print two labels on prescriptions, logistical challenges, and the limitation of such a program. We have grave concern about removing liability protection that we discussed today. With that said, we will make the commitment to work with the bill sponsor to find a solution that will help address the bill.

Bryan Wachter, Senior Vice President, Government and Public Affairs, Retail Association of Nevada:
I appreciate the comments of those who spoke before, and certainly from my colleague Ms. MacMenamin. I did want to concentrate on an area or topic of interest that had been brought up, which is Oregon. We heard from the Board of Pharmacy representative that the law in Oregon is still in its implementation stage. I want to stress that is true. The bill has not been enforced or 100 percent implemented yet in Oregon. The reason for that, and why it has taken four years since the passage of the bill to get it done, is because once the current requirements on that bill, and certainly what A.B. 177 requires, go far beyond what is currently available. That is why you have ranges of cost anywhere from $12 million up to $30 million on some of these systems in order to be able to effectively change them and meet the requirements of A.B. 177. One member in Oregon actually quoted $12 a prescription increase in order to be able to meet these requirements. As you know, that is a cost the pharmacy is not going to pass on to the patient, but it is a cost that will have to be absorbed into the cost of doing business for our local pharmacies. That means anytime we have an increase in the cost to business, it puts pressure on employee hours, operation hours, and whether or not that location can remain solvent going forward. Do we expect that to happen? I think we are uncertain because we do not have the information out of Oregon, but it is certainly something we are seriously taking a look at.

I also want to emphasize that right now in pharmacies in Nevada, you can get printed instructions for medications for all the languages the Majority Leader shared on her screen earlier [Exhibit D]. That is something we are proud of. It highlights the fact that outside the clinical setting, patients have access to a toll-free, certified translator who can help them understand their medication. This is especially important because there are some terms that are not easily translated—infusion drugs, for instance. "Infusion" is typically not a phrase that can be easily translated. In this case, it is helpful to have a live translator who can help walk through exactly what the intent of that is and how that patient can actually get the medicine in the most proper and effective way. For those reasons, I join those in opposition, and we look forward to working with the Majority Leader further on the bill.

Chair Jauregui:
Is there anyone else wishing to testify in opposition? [There was no one.] We will move to testimony in neutral. Is there anyone wishing to testify in neutral? [There was no one.] Majority Leader Benitez-Thompson, would you and Ms. Ballard like to give any closing remarks?

Assemblywoman Benitez-Thompson:
I look forward to the continuing work with the stakeholders that we are going to do on this, including the Retail Association of Nevada and working with pharmacists. It has been really helpful for me to actually talk directly with a number of pharmacists because they can help me get down to the nitty gritty about their daily operations and how things are working. That has been one of the most helpful things in this bill.

There are two pieces mentioned on the record that I think I might ask for more clarification on. If that can come in writing, that is fine. I think we heard the testimony that translation services are available everywhere. I want to make sure that is not misrepresentative to mean if you have a service that is readily available to patients. Pharmacies have the ability to call in and do verbal translations there. But when you go into the home, and in conversations I have had with the pharmacists, they have the toll-free number in the pharmacy, but they do not print it on the bottle. If you are at home with your medication bottle, you are left unsure about how to call. If you do call in, you have a person with limited English proficiency reading the bottle to a translator. You really need a translator between the two languages. Otherwise, it does not work to call into translation services where you are reading something in another language. I hope you get what I mean there. That is the crux of when you have that phone call with the pharmacist right there. The pharmacist is speaking in English, and the person is translating to the other person. If you just call in, you are going to lose some of that because the limited English proficiency person will be reading a label back to a translator.

The other thing mentioned on the record was that you have the ability to get all of your prescriptions and instructions right now. I want some clarification on that because there are different pieces out there. This bill is specific to NRS 639.2801, which is the label on the bottle. There are other things like medication guides or patient inserts. I am confused about what is available in other languages, but I will say that in my practice, I have never come across those. There might be a chain provider or one pharmacy that has the ability to print things in English and Spanish because most pharmacies can do English and Spanish right now. I want to make sure they are not misrepresenting that they can print a label in all of the different languages or that is the standard across all pharmacies. I want to make sure you are not thinking I am asking you to have a big policy conversation about something that is already out there and happening.

Ultimately, I really do feel this is the right thing to do. I know the right thing to do can come at a cost, and I want to minimize those costs. I know we heard testimony that Oregon has taken a while to implement their law, but I think part of that has been a lot of generosity to give a long implementation time. I want to be considerate of the implementation time,

but I also want to be considerate of the fact that at some point if we are going to do this, we make an affirmative public policy decision that this is best for Nevada, the residents, and the health care system overall and that we get there. I look forward to ongoing conversations.

Chair Jauregui:
With that, I will close the hearing on A.B. 177. The next item on our agenda is Assembly Bill 178 presented by one of our members, Assemblywoman Melissa Hardy. I will now open the hearing on Assembly Bill 178.

Assembly Bill 178: Revises provisions relating to prescription drugs. (BDR 57-71)

Assemblywoman Melissa Hardy, Assembly District No. 22:
Today, I would like to present Assembly Bill 178, which ensures Nevadans have access to their prescription medications during a state of emergency or declaration of disaster. The COVID-19 pandemic highlights the need to reconsider the rules that limit access to needed prescription drugs for Nevadans, such as older adults and people with underlying health conditions, during a declared state of emergency or disaster. Insurance companies generally impose strict limits on the frequency of medication refills. Outside of times of crisis, there are valid reasons insurance companies limit when and how much of certain medications people can obtain at one time. They could be misused, misplaced, or even sold on the black market. Therefore, many people obtain a one-month supply of medicine at a time, which works well for them.

One year ago, to facilitate the state's response to the COVID-19 pandemic, Governor Sisolak declared a state of emergency. Nevadans were asked to limit nonessential activities due to the pandemic and were encouraged to limit their trips outside their homes to gather essential items such as food and prescription medications in order to stay safe and healthy. During this same time, the Centers for Disease Control and Prevention encouraged those at higher risk, particularly older adults and those with underlying health conditions, to have at least a 30-day supply of prescription drugs and talk to a health care provider, insurer, or pharmacist about obtaining an extra supply of their prescriptions, if possible, to reduce their trips to a pharmacy.

As to many of my bills, the genesis of them is from personal experience or in conversations with constituents. I actually had this happen with my own mom. She takes blood pressure medication, and she needed to get that refilled. At the time, she was uncomfortable and did not feel like she wanted to go to the doctor and she was not able to go to the doctor or to a pharmacy to get the refill. She is very independent and intelligent and usually takes care of everything she needs on her own, but this took a little bit of work. Even for me, we had to go through several loops and processes in order to get that medication for her. Through that experience came the desire to bring this legislation forward.

Especially during the COVID-19 pandemic, people need easy access to their medications, which may be difficult during times of social distancing and their limited ability to meet with health care practitioners. States throughout the country have addressed prescription

medication refills in times of natural disasters or a declared state of emergency. At least eight states—Arizona, California, Florida, Maryland, Oklahoma, South Carolina, Texas, and Washington—allow pharmacists to dispense early and/or provide refills of a prescription under certain circumstances. This measure also shifts how we cover prescriptions during a declared state of emergency or natural disaster in our state.

I am going to give a brief summary of the bill. It would require insurers, such as individual health insurance, group and blanket insurance, health insurance for small employees, fraternal benefit societies, reciprocal insurers, health maintenance organizations, managed care, Medicaid, the Public Employees' Benefits Program (PEBP), and local governments that provide prescription drug coverage to their employees to:

- Waive any restrictions on the time period within which a covered prescription may be refilled for an insured who has not exceeded the number of refills authorized by the prescribing practitioner and lives in the area of the state of emergency or declared disaster within a certain time; and
- Authorize payment for a supply of a covered prescription drug for up to 30 days for any insured who requests a refill under those conditions.

The Commissioner of Insurance may extend the time periods as he or she determines necessary.

To respond effectively to urgent demands during a state of emergency or natural disaster, the public may need increased access to therapeutic pharmaceuticals. Meeting this need requires safely expanding access to pharmacy services and providing temporary and limited relief from certain regulatory restrictions to enhance the operational capacity, flexibility, and efficiency operations.

Currently, a pharmacist may refill a prescription only for the number of times authorized or for the number of times authorized by the prescribing practitioner. Assembly Bill 178 creates an exception to this rule to allow a pharmacist to fill or refill a prescription in an amount that is greater than the amount authorized by the prescribing practitioner but does not exceed a 30-day supply of the drug if:

- The drug is not a controlled substance listed in schedule II;
- The patient lives in an area where a state of emergency or disaster applies; and
- The drug is necessary for the patient's maintenance of life, or the continuation of therapy for a chronic condition and interruption of therapy using the drug may be detrimental to the person's health or produce physical or mental discomfort.

A pharmacist who dispenses drugs under these conditions is required to issue and maintain a written order for dispensing the drug and notify the prescribing practitioner.

You will notice on the Nevada Electronic Legislative Information System, the fiscal notes from the Department of Business and Industry, the Department of Health and Human

Services, PEBP, and the State Board of Pharmacy indicate there would be no fiscal impact. Most of the local governments note there would be no fiscal impacts as well.

In closing, A.B. 178 helps people maintain a continuous supply of medications during a declared state of emergency or disaster. The bill requires an insurer to waive restrictions on medication refills during a declared state of emergency and authorizes payment for a supply of the prescription drug for up to 30 days. The measure also authorizes a pharmacist to fill or refill a prescription drug to a person living in an area that is declared a disaster or state of emergency in an amount greater than is authorized by a prescribing practitioner but does not exceed a 30-day supply of the drug under certain circumstances.

I have reached out to, and have been working with, some stakeholders on this bill. I value their input and continue to work with them if any concerns arise. That concludes my remarks. Mr. Wuest from the Board of Pharmacy is here to answer questions. If there are any specific legal questions we cannot answer, I would be happy to get those answers from our legal staff.

Chair Jauregui:
Are there any questions?

Assemblywoman Carlton:
You have listed who was in this. I did not hear self-insured groups, which are a lot of folks who work in major industry in Las Vegas. I also did not hear that it would apply to those who use a health and welfare fund. Could you repeat the list or clarify if those two are included in the bill?

Assemblywoman Hardy:
Individual health insurance, group and blanket insurance, health insurance for small employees, fraternal benefit societies, reciprocal insurers, health maintenance organizations, managed care, Medicaid, PEPB, and local governments.

Assemblywoman Carlton:
I do not believe those are actually in there. I know self-insured groups are not under the jurisdiction of the Insurance Commissioner, neither is health and welfare—unless the term "fraternal" you are using is meant to aim in that direction. I just want to make sure if you are trying to include those folks, I want to make it very clear that they would be included. This is just up to a 30-day refill?

Assemblywoman Hardy:
Correct. We were thinking 30 days would allow someone to then be able to either see a physician or have a telehealth visit or something like that. That is something I have been working on with folks. If they think there needs to be a greater amount of days, I am more than happy to work on that. I thought 30 days was something that was reasonable.

Assemblywoman Carlton:
I wanted to clarify that list. Whenever we start listing things, there is always the chance that someone could get excluded. I just wanted to verify that.

Assemblywoman Hardy:
Thank you for bringing it up. I agree, we do not want to leave anyone out. I will make sure that those are covered or see what we can do to include them.

Chair Jauregui:
I have a quick clarifying question. Let us say somebody has a prescription, and it is a 30-day prescription, and they have one refill. If they get their prescription today, and tomorrow a state of emergency is declared, can they immediately get their next 30-day refill?

Assemblywoman Hardy:
The way I would understand it, and this may be a legal question, this would be if they do not have another refill coming up, so they can get it.

Chair Jauregui:
If they do not have another refill coming up, then they would be able to get a refill without a prescription for a refill.

Assemblywoman Hardy:
Correct. Mr. Wuest, is that correct?

Dave Wuest, Executive Secretary, State Board of Pharmacy:
I think there are two components to the bill, the insurance component—which you already put in place in Nevada law around two sessions ago—where people can get a 90-day supply, as long as it was not a controlled substance and they had it filled before. When we are talking about section 19, yes, the patient already had the prescription and there is no refill available, but in a state of emergency, the pharmacist would be able to refill it. Through regulations, the Board has some ability to allow that now, which we have done the best we can. I think this is more comprehensive, and I can tell you that early on in the pandemic, we did a waiver of regulation that would allow pharmacists to do this during the emergency. I have not had one complaint from a patient or doctor that somebody got the medicine they should not have gotten. I think doing it in statute makes sense.

Assemblywoman Kasama:
Are the insurance companies okay with this change? I am sure they probably have a policy that says it has to be one way, and then this will change statute. Has that been run by them, and are they okay with this? Or have they said this is above my pay grade, or if this changes in the statute they must do it? Do you have to coordinate with them for these changes? I am curious how all that works.

Assemblywoman Hardy:
I have not heard of any opposition to that yet. As I said, we have been working with stakeholders and would address those concerns. There has not been anything that I have heard in those regards yet. Yes, according to this, they would be required to pay for that supply every fill.

Assemblywoman Considine:
I have a question, but also to follow-up on Assemblywoman Carlton's questions. In subsection 2 of most sections, talking about the insurer or other entities taking care of the prescription, it says, "The Commissioner may extend the time periods prescribed by subsection 1 in increments of 15 or 30 days as he or she determines to be necessary." Does that mean that even though this says you would have one 30-day prescription, given that the Commissioner could then determine that it can go on for two more weeks or another month, does that extend that time frame?

Assemblywoman Hardy:
I would have to follow that up with the Commissioner unless Mr. Wuest knows that answer.

Dave Wuest:
My reading of it is that those subsections are related to the insurance coverage. Yes, the Commissioner would be able to extend the insurance coverage. Most insurers want their people to get their prescriptions because it keeps them from harm. I think in those subsections, the Insurance Commissioner could extend that. The Insurance Commissioner would not be able to extend section 19 where the pharmacist is giving an extra medication where there is no refill left. Those earlier subsections are talking about when there is a refill available.

Assemblywoman Considine:
I want to get it on the record that the list of the insurance app menus have the same language in section 1, except for Medicaid. It changes a little bit from "shall" to "may." It is my understanding that the Medicaid recipients under this change "shall" get the prescriptions even though the wording in that section has changed. I want to make sure that my understanding is correct, and it is on the record.

Assemblywoman Hardy:
Yes, I did ask that question of our committee counsel, and Mr. Quast provided an explanation for that. I can read it, but it is quite long. He said, "However, I believe these are merely stylistic changes accounting for the differences between the administration of the government Medicaid program and the administration of a private policy of insurers." It was a longer answer, and I can give that to the Committee, but that was his answer.

Assemblywoman Considine:
I wanted his answer to be part of the record to make sure the Medicaid recipient has the same options as all the others.

Chair Jauregui:
Assemblywoman Hardy, that would be great if you can send that response to the committee manager so she can share it with the Committee members. Assemblywoman Considine pointed to subsection 2 of most of the sections, but do we need to add any clarifying language? Right now, there is the same subsection 1 for most sections, and subsection 1 references the state of emergency, but subsection 2 does not. It just says, "The Commissioner may extend the time periods prescribed by subsection 1 in increments of 15 or 30 days . . . ." I do not know if just referencing subsection 1 is enough to say he or she can only extend it for 15 to 30 days during a state of emergency and those powers are not there when we are no longer in a state of emergency.

Assemblywoman Hardy:
I will follow up with that as well.

Assemblywoman Dickman:
I have a quick question. In section 19, where the pharmacist can make the decision to extend the prescription beyond what the physician or practitioner has said, could this open up a pharmacist to a new liability if something went wrong with extending that prescription longer than the doctor had prescribed?

Assemblywoman Hardy:
I will let Mr. Wuest answer that question.

Dave Wuest:
I think that is an excellent question, and I am not an attorney. We might have to ask our committee counsel that question. There might be a provision in there that you would want to protect the pharmacist if that is your intent. It would be clearer to put a provision that if the pharmacist acts in good faith that they cannot be held accountable.

Chair Jauregui:
Assemblywoman Hardy, can you get clarification on that and share it with the committee manager so she can share it with the members?

Assemblyman O'Neill:
Mr. Wuest, I need some clarification. You said the refill can exceed the number that is authorized by the practitioner. If I am out of refills, and we have an emergency, I can still get a refill on my medication. Do I understand that correctly?

Dave Wuest:
It is listed on the Board of Pharmacy website that we have a waiver through regulation, not statute, where during the emergency if there is a patient who needs to get a prescription refilled and they cannot contact their practitioner, the pharmacist could refill that prescription for 30 days. It could not be a controlled substance, and the pharmacist must have notified the practitioner. This language is very similar to the waiver guidance we have. Yes, this would be in an emergency.

From my time with the Board, I have seen it with hurricanes where people have come from other places, and we saw it with the fires in California where people came over, and their pharmacy had burned down. Pharmacists were able to look at stores that were close to them and look at the record, for example, Walgreens. Yes, they would be able to refill a prescription for 30 days, but they have to notify the practitioner as stated in subsection 2. I do not have the sense for how many times this has happened during the current pandemic, but I have not received a complaint that somebody has been harmed by the current guidance. Any time it is in statute, in my mind, that is the best way to say this is what you want, as opposed to me doing some waiver.

Assemblyman O'Neill:
Starting with section 1, subsection 1(a)(1), and section 3, subsection 1(a)(1), it goes on and on again. Just to clarify, it reads on numerous pages, "Has not exceeded the number of refills authorized by the prescribing practitioner."

Dave Wuest:
My interpretation is that it is a different system. It is talking about insurance coverage, and they want to make sure if the patient has a refill that it is covered by insurance. When you get to section 19, that is a separate component that is talking about where there is no refill, and the pharmacist can use his or her professional judgment to give the patient some in an emergency.

Chair Jauregui:
Assemblywoman Hardy or Mr. Wuest, do you know what happens in an instance where a pharmacist issues a prescription and within 48 hours notifies the doctor, and the doctor says it is not a valid prescription, and the patient should not have gotten one? Who is responsible for collecting that prescription back or making sure it stays out of the hands of the patient? What happens next if that does occur?

Dave Wuest:
That is an excellent question. For this particular scenario, the Board of Pharmacy would hold the pharmacist responsible for contacting the patient and communicating to them they should not have the prescription. This comes up already where the doctor has prescribed something and it is filled wrong, or he or she wrote the wrong medication. There is a process where practitioners work together. That happens when the doctor selects the wrong patient and has to contact him or her. I think they work together. You can always put more clarity in there that it is the responsibility of the pharmacist to terminate that prescription if the doctor says no. That could be clarity that can be added to the language. I would hold the pharmacist responsible because he or she made the professional decision to dispense.

Chair Jauregui:
They would be liable and responsible for getting the prescription back, but we would need some clarification because there is no process now for the waivers you issued.

Dave Wuest:
Yes, exactly.

Chair Jauregui:
Are there any other questions? [There were none.] We will move to testimony in support.

Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada:
This simply codifies in statute what is being done during the current pandemic. It has worked well. Our members have not had any complaints, and we have not seen any issues with this at this time. It is important to understand that when the emergency first happened, we were right up against that with people who were panicked with not being able to get their medications. I thank the Board of Pharmacy and Governor Sisolak for working together and making this happen for those patients in Nevada who needed it. I think this bill is a good bill. It has the opportunity to protect the patients in our state.

Chair Jauregui:
Is there anyone else wishing to testify in support? [There was no one.] Is there anyone wishing to testify in opposition? [There was no one.] We will move to neutral.

Julia Peek, Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services:
We were just here to answer any questions. My Medicaid partners are here, as are we for public health. We have no specific comments unless there are questions for us.

Chair Jauregui:
Is there anyone else wishing to testify in neutral on A.B. 178? [There was no one.] Assemblywoman Hardy, would you like to give any closing remarks?

Assemblywoman Hardy:
I will definitely follow up and get the information and continue to work on this. I think it is important, as was stated, when a situation like this arises that we have been in for the last year. It can be scary for people who rely on medications. It can be quite nerve-wracking and cause anxiety to think, "I need this medication, and how am I going to get it?" I think this is important for that; it is for a limited circumstance. We want these people, especially seniors and those who have conditions who rely on their medications, to have the comfort of knowing there is a way in state law to receive the medications they need.

Chair Jauregui:
With that, I will close the hearing on A.B. 178. The last item on our agenda is public comment. Is there anyone wishing to give public comment? [There was no one.] Our next meeting will be on Friday, March 12, 2021. Please be on the lookout for the agenda, and the start time. We will have a work session.

The meeting is adjourned [at 3:28 p.m.].

RESPECTFULLY SUBMITTED:

_____
Julie Axelson
Committee Secretary

APPROVED BY:

_____
Assemblywoman Sandra Jauregui, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a document titled "Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections 2000 to 2038: Estimates from 2000 to 2017 and Projections from 2018 to 2038," prepared by Jeff Hardecastle, AICP, Nevada State Demographer, Department of Taxation, and submitted by Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27, regarding Assembly Bill 177.

Exhibit D is a copy of a document titled "The 2020 Census in Nevada Snapshot #7," submitted by Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27, regarding Assembly Bill 177.

Exhibit E is an email dated March 10, 2021, submitted by Diem Nguyen, Health Navigator, Asian Community Development Council, in support of Assembly Bill 177.

Exhibit F is a copy of a letter submitted by José M. Partida Corona, Private Citizen, Las Vegas, Nevada, in support of Assembly Bill 177.

Exhibit G is a copy of a letter dated March 10, 2021, submitted by Shane Piccinini, Government Relations, Food Bank of Northern Nevada, in support of Assembly Bill 177.

Exhibit H is a copy of a letter dated March 10, 2021, submitted by Estrelita Lacanlale, Private Citizen, Las Vegas, Nevada, in support of Assembly Bill 177.

Exhibit I is a copy of a letter dated March 10, 2021, submitted by Paloma M. Guerrero, Legislative Committee, Nevada Immigrant Coalition, in support of Assembly Bill 177

Exhibit J is a copy of a letter dated March 15, 2021, signed by Ann Silver, Chief Executive Officer, Reno + Sparks Chamber of Commerce, and submitted by Nick Vander Poel, representing Reno + Sparks Chamber of Commerce, in opposition of Assembly Bill 177.